INFORMATION

COURT HOLDS C.P.S. NOT SUBJECT TO INSURANCE LAWS

California Physicians' Service is a service corporation, it is not subject to restrictive laws governing insurance companies and its operations are not under supervision of the California Insurance Commissioner. This is the import of a decision by the California Supreme Court, announced late in August, successfully climaxing for C.P.S. an action at law which that organization had begun in San Francisco Superior Court in 1940.

When C.P.S. was formed in 1939 as a service corporation, the insurance commissioner objected and contended that it was in reality an insurance company and subject to all of the restrictive laws governing insurance. Counsel for C.P.S., Hartley F. Peart and Howard Hassard, advised both the California Medical Association and C.P.S. that in their opinion the rendering of medical care on a prepaid basis through a service corporation in which all doctors of medicine were free to participate, was a professional matter and not an insurance business.

Accordingly, C.P.S. commenced an action against the insurance commissioner for a declaratory judgment. The suit was commenced in 1940. In it C.P.S. sought a judgment of the court establishing its legal right to engage in a prepaid medical service plan. The case was heard by Judge C. J. Goodell, then of the Superior Court in San Francisco, and was decided in favor of C.P.S. The insurance commissioner appealed. The case finally reached the California Supreme Court, and on August 27, 1946, the Supreme Court in an opinion written by Justice Douglas Edmonds decided in favor of C.P.S. and against the insurance commissioner. Six of the seven justices of the California Supreme Court concurred in the main opinion, and one justice concurred in a separate opinion.

As the decision of the Supreme Court is one of first impression, it is a milestone upon the path of voluntary prepaid medical care. Its major features, with certain portions of the opinion and footnotes summarized, follow:

California Physicians' Service, a non-profit corporation (Civ. Code sec. 93-605e), sued to obtain a declaratory judgment that it is not engaged in the business of insurance within the meaning of the regulatory statutes of this state. The insurance commissioner has appealed from a determination adverse to his contentions, and the principal question for decision concerns the organization's right to operate, without his supervision, for the purpose of defraying the expense of medical care incurred by its dues-paying members.

The stipulation by which the evidence in the case was presented to the trial court shows the following facts:

The corporation was organized by the medical profession in 1939 to meet the need of persons in the lower income groups for medical care and surgical service. It holds a certificate of compliance with the provisions of section 593a of the Civil Code, relating to health service corporations, issued by the State Board of Medical Examiners. The incorporators were all officers and councilors of the California Medical Association, an association comprising over 5,000 doctors of medicine practicing in the State of California and constituting a component state unit of the American Medical Association. The Service is a pioneer attempt by the physicians and surgeons of California to make available medical care for those who desire it and, because of financial limitations find the cost of sickness a burden not easy to bear.

The articles of incorporation state that the organization was formed "after more than ten years of continuous investigation and study." As a summary of policies and purposes, it is said "that the duties and obligations of the profession are not only leadership in the maintenance of high standards of medical service but also in the means of distribution of that service so that all who need it may receive it; that the very advances made by modern science have greatly increased the cost of good medical service and hospital care and will continue to increase that cost as new methods and equipment for diagnosis and treatment are discovered and perfected . . . that a method which only the medical profession can most effectively provide is necessary properly to distribute this cost of medical service so as to relieve the intolerable financial burden heretofore falling on the unfortunate few in any given period of time; that the establishment by the profession of a voluntary medical service plan, participated in by all doctors of medicine desiring to do so, will enable the people of the State of California to obtain prompt and adequate medical attention and hospital care whenever needed on a periodic budgeting basis without injury to the standards of medical service, without disruption of the proper physician-patient relation and without profit to any agency, and will assure that all payments made by patients, except administrative costs, will be utilized for medical service and hospital care and not otherwise; that such a plan will create an efficient public and civic service without commercial exploitation of the patients or the profession or any restriction of an individual's fundamental right freely to select, when his need arises, the doctor of medicine and hospital desired by him; and finally, such a coordinated organized service can, upon the same fundamental basis, be the means which governmental agencies—federal, state, and local—may use to provide, at the lowest possible cost to the taxpayer, good medical service and hospital care for the indigent, needy or handicapped residents of California..."

To make effective these broad objectives, the by-laws declare that every resident doctor of medicine who holds "a valid and unrevoked physician's and surgeon's certificate issued to him by the Board of Medical Examiners of the State of California shall be invited by the board of trustees to become a professional member . . . it being one of the fundamental purposes of this corporation that professional membership . . . shall embrace all legally licensed Doctors of Medicine . . ." The professional members select, on a basis of state-wide representation the administrative members, limited to 75, each of whom must be an active member in good standing of the California Medical Association. The voting rights in the corporation are vested in the administrative members exclusively. They elect the directors who are designated as trustees.

The persons who are to receive medical attention from the professional members "on a periodic budgeting basis" are termed beneficiary members . . . (the court describes in detail the contracts with beneficiary members) . . .

The Rural Health Service Agreement which the corporation made with the Farm Security Administration, an agency of the United States, contains substantially the same terms as those of the Group Medical Service Agreement, but there are additional provisions for hos-

pitalization and reimbursement for drugs. Although it is stated in the preamble of this agreement that it is of an experimental nature and binding only for a specified period, the stipulation of facts recites that it "has been adopted by California Physicians' Service and is in use at the present time."

. . . (Rural Health Service Agreement is summarized) . . . Each professional member agrees, by written contract with the corporation, to render such needed medical attention to beneficiary members as may properly be requested of him and, for the payment of compensation for such services, to look solely to the available funds of the organization. But every physician "is free to exercise his individual right to refuse to accept any person as a patient." The amount to be paid to a physician is determined by what is known as a unit system, and each professional member agrees to accept as payment in full for his services rendered to beneficiary members during each month a pro rata distribution of that portion of dues collected during such month.

The by-laws describe the unit system and its operation as follows: "By the term 'unit system' is meant a method of computing the compensation due to professional members rendering medical or surgical services whereby a proportional valuation is set upon each kind of service by counting each such service as a determined number of units by resolution of the board of trustees adopting a schedule or schedules of compensation. The total sum of money available for compensation of professional members is divided by the total number of units of service rendered during any given period to determine the monetary value of a single unit for the purpose of compensation earned by professional members and each professional member is paid according to the number of units of service he has rendered in said period. . . .

"In the event that during any period there is available for payment to professional members a sum in excess of the sum necessary to pay the full schedule or compensation established by the board of trustees such excess sum shall be reserved by the board of trustees as a part of the reserve funds of the corporation or if the board of trustees so determines, it may be distributed on a unit system to those professional members who have in any prior period determined by the board received for their services less than the compensation schedule, provided no professional member shall thereby receive more than the full compensation schedule for any service rendered."

Upon this evidence the trial court decreed as follows:

"That rendition of medical and surgical services by the professional members of . . . California Physicians' Service, and the acceptance of payment for such services . . . from funds contributed by the beneficiary members" of the organization "does not constitute the transaction of an insurance business under the insurance laws" of this state. More generally the court declared that the "objects and purposes set forth in the articles of incorporation" of the Service "are lawful objects and purposes and the performance or undertaking by plaintiff of any or all of said objects does not and will not violate any . . . laws of the State of California relating to the business of insurance." Concerning the medical attention which the members receive, the decree recites that "the rendition of medical and/or surgical services . . . does not constitute a violation of the principle that a corporation may not engage in or be licensed to practice one of the learned professions . . ." But the court declared that the collection of money "to be used in the manner and for the purposes outlined in the articles of incorporation of the plaintiff" subjects it to regulation by the Attorney General of California in accordance with the provisions of section 605(c) of the Civil Code relating to non-profit corporations.

As grounds for reversal of the judgment, the insurance commissioner declares that the courts should not place judicial approval upon a controversial type of new business enterprise; also that in the absence of specific statutory authority for declaratory relief against the state or an officer of the state such an action cannot be maintained. The term "person" as used in section 1060 of the Code of Civil Procedure, it is urged, does not include the state or its officers because general words in a statute which might have the effect of restricting governmental powers are to be construed as not applying to the state, and declaratory relief is not available against political subdivisions of the state.

Another contention of the commissioner is that the Service's activities constitute the unlawful practice of medicine by a corporation. Furthermore, he says, section 593a of the Civil Code specifying certain minimum requirements which a health service corporation must meet, and a statute authorizing political subdivisions of the state and public agencies to contract with a non-profit membership corporation for medical service (Stats. 1939, Ch. 250; Deering Gen. Laws 1943, Act 3725) are invalid. These enactments, it is claimed, make an unreasonable classification because the grant of the privilege of corporate practice, based upon the number of licensee members of the corporation, is not related to qualification or fitness. Also, the argument continues, no subsequent legislation has authorized the activities of the Service.

The major ground for the attack upon the judgment is that the Service is engaged in the business of transacting insurance and therefore is subject to the regulatory laws governing such corporations. All of the elements of insurance are present in the Service's plan, says the commissioner. There is no real distinction between service and insurance, and by its contracts the corporation has obligated itself to furnish medical care. The Service's plan of operation is not excepted by statute from the supervision of the insurance department, and the Service is not a consumer cooperative, but a corporation organized for the profit of the professional members. The nature of the medical service, and of the contracts it offers, require the application of the insurance laws to its affairs in order to prevent exploitation of the public. Finally, the commissioner asserts, the judgment goes beyond the stipulated facts in prospectively validating future acts not comprehended in the Service's plan of operations as conducted at the time the decree was entered, and its method of doing business since the notice of appeal was filed shows the necessity for state insurance regulation.

In response to the contentions of the attorney general the Service asserts that declaratory relief is a proper form of action against the insurance commissioner. Also, it replies, the Service is not engaged in the corporate practice of medicine; if so, its functions are expressly permitted by statute.

Turning to the most important question, the Service declares that it is not engaged in the insurance business but is rendering personal service, as distinguished from indemnity, compensation for which is limited to the resources of a pooled fund; that the professional members, not the Service, assume any and all risk; and that it is actually a producer-consumer cooperative. Furthermore, the Service concludes, as a matter of social policy the state, by statute, has declared that a non-profit membership corporation may lawfully defray or assume the cost of medical and surgical services or render any such service. In that regard the argument runs, the legislature has necessarily determined that the rendition of medical and surgical services by a non-profit membership corporation coming within the purview of section 593a of the Civil Code does not constitute that type of insurance assuming it is insurance which is subject to regulation by the

insurance commissioner. In conclusion, the Service maintains that the legislative classification under the applicable code provisions is constitutional.

. . . (the Court reviews prior cases and decides that a declaratory judgment action is proper) . . .

Considering the merits of the case, it is a matter of common knowledge that there is great social need for adequate medical benefits at a cost which the average wage earner can afford to pay. Unquestionably the distribution of these services has lagged far behind production. During the past several decades many plans have been devised to distribute the cost of medical care (see: People v. Pacific Health Corp., 12 Cal. 2d 156; Butterworth v. Boyd, 12 Cal. 2d 140; Pacific Employers Ins. Co. v. Carpenter, 10 Cal. App. 2d 592; 52 Harv. L. Rev. 809-817) and in 1917, the California legislature adopted a constitutional amendment calling for the creation of a system of state medicine financed through taxation (Stats. 1917, p. 1948). This amendment was rejected by the people.

In 1935, similar legislation met defeat. The medical profession then undertook the responsibility for providing medical service on an ability-to-pay-for basis, and it is obvious that the legislature, by enacting section 593a of the Civil Code,[1] expressly authorized the organization of corporations such as California Physicians' Service. By this enactment, the state's social policy in regard to the corporate practice of medicine, to the limited extent specified, has been determined and the courts are bound thereby. (See: People v. Pacific Health Corp., *supra*, p. 161; Pacific Employers Ins. Co. v. Carpenter, *supra*, p. 602; 52 Harv. L. Rev. 809-817; 25 Cal. L. Rev. 91-98; 53 Yale L. J. 162-182.) It is stipulated that the Service has complied with the provisions of this statute and holds a certificate in the form authorized by its provisions.

The statutory provisions authorizing the Service's operations do not violate Art. IV, sec. 25, subd. 19, of the California Constitution which prohibits "granting to any corporation, association, or individual any special or exclusive right, privilege, or immunity." As stated in Livingston v. Robinson, 10 Cal. 2d 730, 740: "The question of classification is generally one for the legislative power, to be determined by it in the light of its knowledge of all the circumstances and requirements, and its discretion will not be overthrown unless it is palpably arbitrary. (Wores v. Imperial Irr. Dist., 193 Cal. 609.) It will be presumed that the legislature made inquiry to determine whether or not there were evils to be remedied and that the classification made was based upon the result of the inquiry." And in People v. Western Fruit Growers, 22 Cal. 2d 494, 507, it was said: "When a legislative classification is questioned, if any state of facts reasonably can be conceived that would sustain it, there is a presumption of existence of that state of facts, and the burden of showing arbitrary action rests upon the one who assails the classification." (See also: Gillum v. Johnson, 7 Cal. 2d 744, 759; State Bar v. Superior Court, 207 Cal. 323, 332; People v. Keith Ry. Equip. Co., 70 A.C.A. 445, 461.) The legislature may classify organizations rendering medical services under the same general principles as those which allow it to license for numerous occupations and professions and public policy certainly permits restriction of the right to assume the cost of such services to such organizations as meet reasonable and definite standards. The interest of the state in the health of its citizens (see: Butterworth v. Boyd, *supra*) fully justifies the legislative classification. The decision relied upon by the attorney general, Van Camp Sea Food Co., Inc., v. Newbert, 76 Cal. App. 445, to support his conclusion is in accord with these general principles but is factually distinguishable.

Considering the question as to the supervision which the state has imposed upon corporations such as the Service, the legislature has defined insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event." (Insurance Code, sec. 22; Civil Code, sec. 2527.) Disability insurance "includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness." (Insurance Code, sec. 106.) Under Chapter 4 (sec. 10272) of the Insurance Code, which deals with standard provisions in disability policies, "indemnity" is said to mean "benefits promised"; while in the Civil Code, sec. 2772, it is defined as "a contract by which one engages to save another from a legal consequence of the conduct of one of the parties, or of some other person." Otherwise stated, "insurance generally may be defined as an agreement by which one person for a consideration promises to pay money or its equivalent, or to perform some act of value, to another on the destruction, death, loss or injury of someone or something by specified perils." (29 Am. Jur., p. 47.)

These definitions clearly state the basic concepts or elements which are a necessary prerequisite of a contract of insurance. "Whether the contract is one of insurance or of indemnity," said one court, "there must be a risk of loss to which one party may be subjected by contingent or future events and an assumption of it by legally binding arrangement by another. Even the most loosely stated conceptions of insurance and indemnity require these elements. Hazard is essential and equally so a shifting of its incidence. If there is not risk, or there being one it is not shifted to another or others, there can be neither insurance nor indemnity. Insurance also, by the better view, involves distribution of the risk, but distribution without assumption hardly can be held to be insurance." (Jordan v. Group Health Ass'n., 107 Fed. 2d 239, 245; see also: Fageol T. & C. Co. v. Pacific Indemnity Co., 18 Cal. 2d 731; Gregg v. Comm'r. of Corp. & Tax. (Mass.), 54 N.E. 2d 169; Comm'r. Banking & Ins. v. Community Health Service (N.J.) 30 Atl. 2d 44; Stern v. Rosenthal, 128 N. Y. Spp. 711; State v. Universal Service Agency (Wash.), 151 Pac. 768; 53 Yale L. J. 172; 23 Corn. L. Q. 188, 193; 119 A.L.R. 1241; 100 A.L.R. 1449; 63 A.L.R. 711; *Vance*, Insurance, 2d ed., p. 57.) Although some authorities have held that to constitute insurance the so-called insured must be indemnified by the payment of money (Jordan v. Group Health, *supra*, p. 245, note No. 13; Moresh v. O'Regan (N. J.), 187 Atl. 619; 5 *Elliott*, Contracts, sec. 4020), or that statutes regulating insurance were intended to apply only to concerns

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1 "Sec. 593a (Health service corporations: Prerequisites to commencement of business: Supervision.) A nonprofit corporation may be formed under this article for the purpose of defraying or assuming the cost of professional services of licentiates under any chapter of Division 2 of the Business and Professions Code or of rendering any such services but it may not engage directly or indirectly in the performance of the corporate purposes or objects unless:

"(1) At least one-fourth of all licentiates of the particular profession become members;

"(2) Membership in the corporation and an opportunity to render professional services upon a uniform basis is available to all licensed members of the particular profession;

"(3) Voting by proxy and cumulative voting are prohibited; and

"(4) A certificate has been issued to the corporation by the particular professional board, whose licentiates have become members, finding compliance with the foregoing requirements.

"Any such nonprofit corporation shall be subject to supervision by the particular professional board under which its members are licensed and shall also be subject to the provisions of Section 605c of this code. This section, except as expressly permitted herein, does not authorize the formation of any corporation for the purpose of rendering the professional services regulated by Division 2 of the Business and Professions Code. (Added by Stats. 1941, ch. 623, sec. 1.)"

organized for profit and not to charitable or nonprofit associations (Hall D'Ath v. British Provident Assoc. (1932), 48 Times L. R. 240; State v. Taylor (N. J.), 27 Atl. 797), there are more substantial reasons upon which to base a determination as to the status of the California organization.

The business of the Service lacks one essential element necessary to bring it within the scope of the insurance laws, for clearly it assumes no risk. Under the provisions of the contracts or group agreements, it is a mere agent or distributor of funds. It does not promise the beneficiary members that it will provide medical care; on the contrary, "the services which are offered to . . . beneficiary members of C.P.S. are offered personally to said members by the professional members of C.P.S. . . ." (See: Jordan v. Group Health Assn., *supra*, p. 246; Phez Co. v. Salem Fruit Union (Ore.) 201 Pac. 222.) The professional member is compensated for his services solely from the fund created by the monthly dues to the beneficiary members. Payments from the fund are made to the physician pro-rata in accordance with an established schedule. Under that plan, the amount of compensation of the professional members is variable and may be high or low, depending upon the incidence of sickness and the number of beneficiary members paying dues. Stated in terms of insurance, all risk is assumed by the physicians, not by the corporation, hence the only effect of requiring compliance with regulatory statutes would be to compel the acquisition of reserves contrary to the established method of operation. (See: Jordan v. Group Health Assn., *supra*, p. 251.)

This distinction has been recognized and applied by other courts which have considered the same question. In Jordan v. Group Health Assn., *supra*, the organization which distributed funds for medical care sought a declaration of its statute under the laws of the District of Columbia which define insurance in substantially the same terms as the California statutes. The corporate purpose of the association and its method of doing business was similar to that of California Physicians' Service. The court held that the corporation had assumed no risk. This conclusion applies more exactly to the California organization because of the total lack of a promise by the corporation to the beneficiary members to render any medical care. Except for the limited hospitalization obtainable by rural members in connection with the Farm Security Administration contract, the Service does not even promise to "use its best efforts to procure the needed services" as the District of Columbia corporation agreed to do, and does not obligate itself to pay the physicians a certain sum per month. The California physicians look solely to the monthly dues of the beneficiary members for compensation.

The case of State v. Universal Service Agency (Wash.), 151 Pac. 768, relied upon in the Jordan case, *supra*, p. 249, was an action by the insurance commissioner to forfeit the corporate franchise of the organization upon the ground that it was "doing an insurance business without complying with the statutes regulating the doing of such business." The applicable definition of insurance was similar to, if not identical with, that of this state, and the method of doing business was the same as that of the California Physicians' Service, including the type of contract used. And again the want of assumption of any hazard or risk was the basis for holding that the corporation was not engaged in the insurance business.

In the case of Commissioner of Banking and Insurance v. Community Health Service, Inc., 129 N.J.L. 427, 30 Atl. 2d 44, the insurance commissioner sued the defendant corporation to recover a statutory penalty for conducting an unlicensed insurance business. The corporation had made contracts with licensed physicians under which they agreed to render professional services for a certain stipulated compensation to those members of the general public who paid the corporation a specified sum each month. The physicians' services were engaged by the corporation for a period of one year, and from year to year thereafter, for a fixed consideration which varied with the number of contract holders but not with the amount of service rendered by the physician to any or all of the contract holders. The court, relying upon State v. Universal Service Agency, *supra*, and Stern v. Rosenthal, 128 N.Y.S. 711, held that the corporation was not engaged in the business of insurance because, as between the corporation and the physician, nor between the physician and the subscriber, was the compensation or any other element of the arrangement between them affected by any contingency, hazard or risk which the corporation assumed and insured against. (See also: Vrendenburgh v. Physicians Defense Co., 126 Ill. App. 509; State v. Laylin, 73 Ohio St. 90; 53 Yale L. J. 172.)

In both the Jordan case, *supra*, and in State v. Universal Service Agency, *supra*, as is true in the present case, reliance was placed upon Physicians' Defense Co. v. O'Brien, 100 Minn. 490, Physicians' Defense Co. v. Cooper, 199 Fed. 2d 576, and State v. Globe Casket Co., 82 Wash. 124. The Physicians' Defense cases involved contracts to supply legal service to physicians in malpractice suits; the latter one concerned an agreement for burial expense. But in each of those cases there was a contract providing indemnity against a hazard which might cause loss to the corporation and, for that reason, the decisions are not herein point.

There is another and more compelling reason for holding that the Service is not engaged in the insurance business. Absence or presence of assumption of risk or peril is not the sole test to be applied in determining its status. The question, more broadly, is whether, looking at the plan of operation as a whole, "service" rather than "indemnity" is its principal object and purpose. (Jordan v. Group Health Ass'n., *supra*, pp. 247 et seq.; see: Vrendenburgh v. Physicians' Defense Co., *supra*, p. 513; State v. Laylin, *supra*, p. 98; Commonwealth v. Provident Bicycle Ass'n., 178 Pa. 636, 642; Sisters of Third Order of St. Francis v. Gillaume, 222 Ill. App. 543; 3 Univ. of Pittsburgh L. Rev. 250; 52 Harv. L. R. 814, 815; 23 Corn. L.Q. 188; 29 Mich. L. Rev. 378; *Vance*, Insurance, p. 61.) Certainly the objects and purposes of the corporation organized and maintained by the California physicians have a wide scope in the field of social service. Probably there is no more impelling need than that of adequate medical care on a voluntary low-cost basis for persons of small income. The medical profession unitedly is endeavoring to meet that need. Unquestionably this is "service" of a high order and not "indemnity."

The fact that the Rural Health Service Agreement provides for limited hospitalization does not make the business of the Service that of insurance. So far as the record shows, a participating hospital must look only to the pooled fund of the Service for payment for facilities furnished to a beneficiary member. Also, the additional features of hospitalization and reimbursement for drugs are not distinguishable from other medical care obtainable on the group basis, and they are merely incidental to the plan or scheme as a whole. (See: Jordan v. Group Health Assn., *supra*, p. 244 note No. 10.)

Furthermore, the legislature by the enactment of section 593a of the Civil Code, with its express provision for limited regulation of nonprofit organization of a professional character by the attorney general and the particular professional board, necessarily intended that such organization should be exempt from regulation by the insurance commissioner. (See: 52 Harv. L. Rev. 816; 53

Yale L. J. 171 et seq.) One of the reasons behind the declaration of the earlier cases that it was against public policy for a corporation to engage in the practice of medicine was because the control of its activities was placed in the hands of laymen. (See: Pacific Employers Ins. Co. v. Carpenter, *supra;* Painless Parker v. Board of Dental Exam., 216 Cal. 285, 296; 52 Harv. L. R. 811; 53 Yale L. J. 170.) To allow the insurance commissioner to impose the extensive regulations provided for in the Insurance Code upon the activities of the Service would result in the same evil. (See: Yale L. J. 171.) Since section 593a of the Civil Code is applicable to the organization whose status is here under attack, it must be presumed that the legislature weighed this evil against possible exploitation of the public and concluded that the limited regulation provided by the new statute was sufficient. Also, it may be noted, section 433.6 of the Political Code dealing with payroll deductions for state employees who join any group medical plan, makes a clear distinction between regular insurance companies and "non-profit membership corporations organized under the laws of this State, for the purpose of defraying the cost of medical services. . . ." (See also: Stats. 1939, ch. 250 p. 1505; Stats. 1940, First Extra Session, ch. 45, sec. 6.7.)

This conclusion becomes more apparent when the purpose and nature of many of the legislative requirements are considered, particularly those relating to the maintenance of reserves and to the regulation of investments and financial operations. The extensive insurance regulations primarily are designed to protect the insured or the public, from the insurer. (52 Harv. L. Rev. 815.) Such regulations become important only if the insurer has assumed definite obligations; conversely, it is evident that they are not intended to apply where no risk is assumed and no default can exist. Furthermore, by the very nature of its operations, the Service could not accumulate vast reserves. The flow of funds from patient to physician primarily is on a monthly basis of pay-as-you-go and to require reserves would be a useless and uneconomic waste. (Jordan v. Group Health Ass'n., *supra,* p. 251; see: 53 Yale L. J. 171.)

For these reasons the respondent is not engaged in the business of insurance within the meaning of the regulatory statutes but is subject to the limited supervision provided by sec. 593a of the Civil Code. The judgment of the trial court in this regard is not too broad, for every decision is limited to the evidence upon which it is based.

EDMONDS, J.

WE CONCUR:
Shenk, J.
Ward, J. Pro. Tem.
Carter, J.
Peters, J. Pro. Tem.

I CONCUR IN THE JUDGMENT: Schauer, J.

CONCURRING OPINION
Gibson, C. J.

CONCURRING OPINION

I concur in the judgment solely on the ground that the Legislature, by the enactment of section 593a of the Civil Code, exempted organizations coming within its scope from regulation by the Insurance Commissioner. By providing for supervision by a professional board and by the attorney general (Civ. Code, secs. 593a, 605c), the Legislature has evidenced an intention to free such organizations from other regulation and from the necessity of complying with the various requirements, such as the maintenance of reserves, which are imposed on regular insurance companies. The need for regulation or supervision, the amount thereof and the persons, bodies or officers who should supervise or regulate are all matters which are confided to the Legislature, and it was within the legislative discretion to provide that a limited regulation of such nonprofit organizations was sufficient.

I cannot, however, concur in that portion of the opinion declaring that the plaintiff is exempted from regulation by the Insurance Commissioner because it is not engaged in the business of transacting insurance, but is merely agreeing to render service. The true test is not the character of the consideration agreed to be furnished, but whether or not the contract is aleatory in nature. A contract still partakes of the nature of insurance, whether the consideration agreed to be furnished is money property or services, if the agreement is aleatory and the duty to furnish such consideration is dependent upon chance or the happening of some fortuitous event. (See Rest., Contracts, sec. 291.) In the present case the agreement is to make payments to member doctors for medical services to the beneficial members and the duty to make such payments is obviously dependent upon chance or the happening of a fortuitous event, since the necessity for the services, and also for the agreed payment, is dependent upon the members' sickness or accidental injury.

GIBSON, C. J.

Clinical Laboratory Technicians Must Be Licensed

Because of repeated indications that "a number of physicians throughout California are not conversant with provisions of the Clinical Laboratory Act" relative to employment of clinical laboratory technicians, W. L. Halverson, M.D., Director of Public Health, has asked CALIFORNIA MEDICINE to call attention to some of the salients.

"This law," Dr. Halverson says in a letter to the editor, "requires that any technicians who engage in clinical laboratory work shall be in possession of a license issued by the California State Department of Public Health. Violation of the Act, either on the part of the technician or of the employer, is a misdemeanor."

The letter continues: "While physicians may legally operate clinical laboratories under their license as physician and surgeon, this does not exempt them from the provision of the law requiring the employment of licensed technicians to actually do the work in the laboratory. It has been our observation that many physicians are not cognizant of this requirement. While the law does permit one apprentice to work in a laboratory, this is with the proviso that such apprentice be under the direct supervision of licensed personnel.

"It should also be noted that any physician who assumes the responsibility for directorship of a laboratory must actually spend sufficient time in the laboratory to supervise adequately the work of the personnel. Under the provisions of the law, supervision cannot be delegated to a technician on the staff who holds only a clinical laboratory technician's license.

"Detailed information concerning the provisions of the law may be secured by physicians from the Division of Laboratories, 3093 Life Sciences Building, Berkeley 4. Copies of the law and the regulations adopted under the law will be sent upon request."